International Patient Questionnaire

Please fill out form in English

Date: _____ **Has this patient been seen at Gillette?** ☐ **Yes** ☐ **No**

PATIENT DEMOGRAPHICS

Patient **First** Name: _____ Address: _____

Patient **Middle** Name: _____ _____

Patient **Last** Name: _____ _____

Date of Birth: _____ City _____

Gender: ☐ Male ☐ Female Country: _____

Email _____ Phone Number

PARENT / LEGAL GUARDIAN INFORMATION

Mother's Name: _____ ☐ N/A Contact Email: _____

Father's Name: _____ ☐ N/A Contact Email: _____

Legal Guardian: _____ Address: _____

Relationship to Patient: _____ _____

Contact Email: _____ City _____

Documentation of Guardianship: ☐ Yes ☐ No ☐ N/A Country: _____

COMMUNICATION / SPECIAL NEEDS

Patient Verbal? ☐ Yes ☐ No Method of Communication: _____

Interpreter Needed? ☐ Yes ☐ No Language: _____

SYMPTOMS/REASON FOR REFERRAL

DIAGNOSIS:

☐ Epilepsy/Seizure Disorder ☐ Cerebral Palsy ☐ Spina Bifida ☐ Spinal Cord Injury

☐ Muscular Dystrophy ☐ Polio ☐ Brain Injury ☐ Spinal Muscular Atrophy

☐ Chromosomal Abnormalities ☐ Other: ☐ Unknown

Other Medical Conditions (in addition to reason for visit)

Is patient on a ventilator? ☐ Yes ☐ No

Has the patient ever been diagnosed with tuberculosis, MRSA, or any other communicable disease? ☐ Yes ☐ No

If yes, please specify:

PAYMENT: Do not leave blank

☐ Self ☐ Embassy ☐ MIM ☐ Sponsoring Organization ☐ Insurance

Insurance Name _____ Address: _____

Policy Holder _____ Group Number _____ ID Number _____

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